THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3361.M5

MDR Tracking Number: M5-04-2146-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-15-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. One evaluation and management code per week from 4-16-03 through 4-28-03 and one evaluation and management code per week from 5-2-03 through 5-30-03 **were found** to be medically necessary. The therapeutic exercise on 4-30-03, the therapeutic exercise from 5-2-03 through 5-12-03 and the therapeutic activities from 7-9-03 through 7-18-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-10-04, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- CPT Codes 97139-ME, 97035, 97032 for dates of service 4-15-03, 4-16-03**,** and 1 unit of CPT code 97530 on 7-9-03, 7-14-03 and 7-16-03 were denied with an F – "The procedure exceeds the maximum fee schedule payment for value and or time on a single date of service." The 1996 MFG Medicine Ground Rules state, "A physical medicine session is defined as

any combination of FOUR modalities." These procedures violate that ground rule as more than four modalities were provided on these dates. **No reimbursement is recommended.**

- CPT Code 97530 for dates of service 4-18-03, 4-22-03 and 5-5-03 were denied as F – Reduced or denied in accordance with the appropriate fee guideline ground rule and/or MAR. The 1996 MFG Medicine Ground Rules state, "The maximum amount of time allowed per session is two hours." The requester has billed for 9 sessions or 2 ¼ hours of physical medicine. **No reimbursement is recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 4-16-03 through 7-16-03-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 18th day of November 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

November 9, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT

Re: Medical Dispute Resolution
MDR #: M5-04-2146-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
H&P and office notes, FCE (04/17/03), physical therapy notes (04/15/03 – 07/18/03), operative (11/14/03) & radiology (04/29/03 & 10/02/03) reports.

Clinical History:
The medical records provided for review indicated that the claimant was 51 years old at the time she sustained an injury to her right knee on ___. The records indicate the patient did not require immediate emergency medical attention. In fact, she delayed reporting the injury until the following day at which time her employer referred her to the emergency room. The ER physician evaluated the patient, prescribed medication, and referred her for an orthopedic consultation.

Apparently, the patient was not pleased with the services and changed treating doctors on 04/14/03. The claimant sought chiropractic services on the above date. The new treating chiropractor diagnosed the patient's right knee pain condition as a probable tear of the lateral meniscus and infrapatellar bursitis. He proposed structured physical therapy and rehabilitation in conjunction with a home exercise program. He expected the duration of these services to last 6-8 weeks. The patient failed to respond to an initial course of chiropractically-managed therapy and rehabilitation services and was referred for MRI on 4/29/03, which revealed patella chondromalacia grade 2 degenerative change in the posterior horn of the medial meniscus with tear. Chiropractic services continued throughout May of 2003.

The treating chiropractor referred the patient for an orthopedic surgical consultation. Subsequently, the patient underwent medial meniscal repair, chondroplasty of the patella, medial femoral condyle, and tibial plateau on 05/30/03. These records indicate that postoperative rehabilitation services managed by the treating chiropractor were initiated or resumed on July 9, 2003 and continued for an undisclosed period. The interim office visit chart notes submitted by the treating chiropractor indicated the patient continued to experience a periodic locking of the right knee. She was referred for a second MRI on 10/2/03, which revealed grade 2 degenerative change in the posterior horn of the medial meniscus without evidence of residual tear or re-tear, moderate chondromalacia of the patella, and doubtful evidence of loose body. A second surgical procedure was carried out on 11/14/03. The procedure was defined as a chondroplasty to the medial femoral condyle and patella.

Disputed Services:
Office visits (04/15 – 04/28/03), therapeutic exercise (04/30/03), office visits & therapeutic exercise (05/02 – 05/12/03), one instance of therapeutic activity (07/09 – 07/18/03).

Decision:
The reviewer partially agrees with the determination of the insurance carrier as follows:

1. The evaluation and management codes for assessments performed from 04/16 through 04/28 were in part reasonable and necessary case management services. One (1) evaluation and management code per week during the period in question was medically necessary.
2. The charges associated with 60 minutes for four (4) units of therapeutic exercise performed on 4/30/03 were not reasonable, necessary, or appropriate. The treating doctor should have been informed or aware of the nature and the extent of the worker's right knee injury, which warranted/demanded surgical consultation, as had been previously indicated by the first treating doctor.
3. The therapeutic exercise services from 05/02/03 through 05/12/03 were not reasonable, necessary, or appropriate. However, one (1) evaluation and management service during the same period (05/02/03 through 05/30/03) should be anticipated as reasonable and necessary case management services.
4. The therapeutic activity from 07/09 through 07/18 was not medically necessary. A reasonable duration of postoperative rehab services or rehabilitation services should have been anticipated by the carrier. The duration for these services should be consistent with the Texas Worker's Compensation lower extremity treatment guidelines and peer-reviewed medical literature.

Rationale:

1. The clinical records submitted by the treating chiropractor supported this level of service and the nature and extent of the worker's injury justified continued assessment until definitive MRI results were obtained; therefore, one (1) evaluation and management service per week was reasonable and necessary.

2. It was not reasonable necessary or appropriate, and in fact counterproductive to continue 60 minutes of therapeutic exercise, which included full weight-bearing, flexion and extension, squats, lunges, and stair-stepping for a patient with credible medical evidence of a meniscal tear and moderate chondromalacia of patella. Upon being made aware of these conditions, the prudent chiropractor would have discontinued those therapeutic exercise activities and arranged for orthopedic surgical consultation post haste.

3.Therapeutic exercise performed from 05/02/03 through 05/12/03 was not reasonable, necessary, or appropriate based on the same rationale as item #2.

4. A reasonable course of postoperative rehabilitation services for the patient's right knee should have been anticipated and allowed by the carrier. The Commission's lower extremity treatment guidelines provide for up to two (2) months of primary and two (2) months of secondary level treatment for lower extremity injuries of this nature. Current peer-reviewed medical literature indicates 12-16 weeks of structured rehab is, in fact, reasonable and necessary for surgical procedures performed.

Sincerely,